STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155758	A. BUILDING _____ B. WING _____	02/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY TOWERS RETIREMENT COMMUNITY	102 W POPLAR STREET GREENCASTLE, IN46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00085414. Complaint IN00085414 - Substantiated, federal/state deficiencies related to the allegations are cited at F329 and F502. Survey date: February 10, 2011 Facility number: 001120 Provider number: 155758 AIM number: 200525120 Survey team: Joyce Hofmann, RN Census bed type: SNF: 22 SNF/NF: 23 Residential: 52 Total: 97 Census payor type: Medicare: 7 Medicaid: 16 Other: 74 Total: 97 Sample: 4 This deficiency also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 2/15/11 by Jennie	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Bartelt, RN.			

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F0329 SS=D	Based on interview and record review, the facility failed to monitor the resident's labwork related ot blood coagulation time, used for therapeutic dosing of anticoagulant medications for 1 of 3 residents reviewed in a sample of 4 for PT/INR [Protime/International Normalized Ratio] testing. [This is a blood test used to evaluate the effect of administration of anticoagulant drugs]. Resident #C Findings include: The Assistant Director of Nursing [ADoN] was interviewed during initial tour of the Health Care Unit on 02/10/11 at 11:10 a.m. and indicated Resident #C was interviewable, independent, and had been sent to the hospital for bruising on her abdomen. Resident #C's clinical record was reviewed on 02/10/11 at 11:40 a.m. and indicated the resident was admitted to the facility on 01/06/11	F0329	F 329 483.25 (l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGSEach resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose; or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documentd in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. No residents were harmed by this deficient practice.On 02/14/11, after searching through some files in my office, The DON was able to locate the fax confirmation and original requistion for the PT/INR that was being sought by the State surveyor. On 02/14/11 the Director of Nursing creased a new monitoring log book.. All licensed nurses have been	02/18/2011

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	and had diagnoses which included, but were not limited to, left hemispheric infarction, elevated troponin, hypertension, hyperlipidemia, degenerative joint disease, status post renal cell carcinoma, history of pneumonia, history of congestive heart failure, history of left leg cellulitis, left knee replacement, 2009, right hip replacement 2007, history of pulmonary emboli, constipation, hypercholesterolemia, gastroesophageal reflux disorder, and history of chronic obstructive pulmonary disease. Resident #C's care plans indicated a care plan dated 01/06/11 for the Resident at risk for ecchymosis secondary to anticoagulant therapy and had a goal of "Resident will not have ecchymosis larger than 12.5 centimeters TNR [till next review]." Interventions included, but were not limited to, "Medications and labs as MD ordered."		in-serviced on the new procedure and use of the forms contained in the binder. The in-service was held 02/14/11--02/1811 as a one on one dicussion between each nurse and the Director of Nursing. The binders have been placed on each unit and the procedure will be implemented on 02/18/11. Each nurse is to glance at the log upon coming on duty to make certain that labs ordered for that day have been signed off as being completed, and if not, to investigate the reason why they have not been done. The Director of Nursing will observe each book on a weekly basis as a second check to ensure the charge nurses are getting the lab log completed accurately. Monitoring will be ongoing.	

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	The Physician's Orders dated January 2011 indicated Resident #C had an order for Aspirin [anti-coagulant] 81 mg every a.m., Lovenox [anti-coagulant] 1 mg sq [subcutaneous] every 12 hours, and Coumadin [an anti-coagulant] 5 mg daily, among other medications. Daily Skilled Nurses Notes dated 01/15/11 at 6 a.m. indicated the resident complained of abdominal pain and nausea. Tylenol was given for abdominal pain and an assessment of the abdomen was made. Bruising was noted on the right side which measured 13 cm x 31 cm dark purple/blue in color with a 3.5 cm x 4.5 cm dark red area that was hard/knot in the center. The left side measured a 5 cm x 13 cm purple/blue/yellow/green bruise. The note also noted an late entry for 3:20 a.m. for a call placed to laboratory due to labs of a PT/INR and lipid panel not drawn which were due on 01/12/11.			

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The notes indicated the medical doctor was notified the the issues via phone at 7:45 a.m. on 01/15/11 and a stat [immediate] PT/INR was ordered and the lab was notified and the lab was drawn.

The nurse's notes at 9:30 a.m. on 01/15/11 indicated the resident complained of pain of a score of 9 on a scale of 1 to 10 with 10 being the highest pain level and 1 very light pain. The knot measured 3.5 cm x 5.5 cm and the medical doctor was paged. Lab results were not back yet. At 9:45 a.m., the medical doctor gave new orders to send Resident #C to the emergency room for evaluation and treatment of abdominal pain and bruising. The resident was sent out and the family was notified.

The lab results for 01/15/11 indicated a Prothrombin Time of 17.7 which was high [as reference range was 9.1-11.1] and an INR of

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	1.8 which was high [as reference range was 0.9 - 1.1]. Notes at 11:55 a.m. indicated the resident returned from the emergency room with new orders to discontinue the Lovenox and to use a heating pad to abdomen as needed. The family was notified. Review of the January 2011 Medication Administration Record [MAR] indicated the physician's order for the PT/INR had been transcribed onto the MAR, and a date for the lab work to be completed was indicated on 01/12/11. No nurse's initials on the date marked for the lab work indicated blood for the lab work had been obtained. The Physician Telephone Orders dated 01/10/11 indicated orders for the following: "... (1) PT/INR on Wednesday 1/12 & call to [name of physician's healthcare facility] ...			

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	(2) fasting lipid panel with 1/12 PT/INR draw ...." Interview with the Director of Nursing [DoN] on 02/10/11 at 1:15 p.m. indicated when labs are ordered, a lab sheet is filled out and put in a box, then the lab person gets the lab sheets out of the box when they come in to draw the labs. The DoN indicated the order for the 01/12/11 lab draw was put on the MAR. Interview with the DoN on 02/10/11 at 2:00 p.m. indicated she had called the lab facility and the lab did not have a copy of the lab requisition sheet. Interview with the ADoN on 02/10/11 at 2:40 p.m. when she investigated the missed lab draw, LPN #1 told her [ADoN] that the lab person could not find the resident at the [name of another facility] as the lab person had her listed as a resident at the [name of			

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	other facility] instead of Asbury Towers. The ADoN's notes indicated the lab supervisor stated the lab had documented on 01/12/11 that Resident #C was unavailable for the lab draw and they had her down as being at another facility instead of at the resident's current location. The notes indicated the facility had fax confirmation that laboratory received the facility's fax which had Asbury Towers name and address. Review of a written statement by the DoN dated 02/10/11 indicated the following: "I was told by [name of ADoN] that she called lab to find out [name of Resident #C] was not drawn on 1/11/11. She stated that lab drawer said resident was unavailable for draw that morning. She was not listed on the printed "draw sheet" that we receive from the lab listing who is due for what test for the day. The nurse in the health center told me that the lab			

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	girl takes the requisitions out of the lab box at the beginning of the month and takes them. I looked through our shred box and found a few from Dec 10 [December 2010] and Jan 11 [January 2011] but not one for _[name of Resident #C]. I called lab and spoke to a representative who reported they "never rec'd [received] the order or at least it is not found in their computer system" only the PT/INR for 01/15/2011 was in the system." The day nurse, RN#1, for Health Care Unit indicated the lab sheet which is faxed to the lab has the facility's name and address on it and is filled out by the nurse with the resident's name, room number, date, date of birth, sex, social security number, and the physician's name. This sheet if faxed to the lab, then in return the lab faxes the facility back a sheet with the resident's name and information which are to be drawn on a certain date. After the lab			

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	person draws the labs, that sheet is signed by the nurse and the lab person and the sheet goes into a notebook. RN #1 could not find Resident #C's name on the sheets for 01/12/11. This federal tag is related to Complaint IN00085414. 3.1-48(a)(3)			

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F0502 SS=D	Based on interview and record review, the facility failed to ensure their laboratory services followed physician's orders for lab tests on date ordered for 1 of 3 residents reviewed in a sample of 4 for PT/INR [Protime/International Ratio] testing [This is a test used to evaluate the effect of administration of anticoagulant drugs]. Resident #C Findings include: The Assistant Director of Nursing [ADoN] was interviewed during initial tour of the Health Care Unit on 02/10/11 at 11:10 a.m. and indicated Resident #C was interviewable, independent, and had been sent to the hospital for bruising on her abdomen. Resident #C's clinical record was reviewed on 02/10/11 at 11:40 a.m. and indicated the resident was admitted to the facility on 01/06/11 and had diagnoses which included, but were not limited to, left hemispheric infarction, elevated troponin, hypertension, hyperlipidemia, degenerative joint disease, status post renal cell carcinoma, history of pneumonia, history of congestive heart failure, history of left leg cellulitis, left knee replacement, 2009, right hip replacement 2007, history of pulmonary	F0502	F 502 SS=D483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELYThe facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.No residents were harmed by this deficient practice.On 02/14/11, after searching through some files in my office, I was able to locate the fax confirmation and original requisition for the PT/INR that was being sought by the State surveyor. The Director of Nursing spoke with Gina Downings, the Medlab customer service representative, regarding concerns with the lab process. On 02/14/11 a new monitoring log book was created and all licensed nurses have been in-serviced on the new procedure and use of the forms contained in the binder. The in-service was held 02/14/11--02/18/11 as a one on one discussion between each nurse and the Director of Nursing. The binders were placed on each unit with their implementation to start on 02/18/11. Each nurse was instructed to glance at the log upon coming on duty to make certain that labs ordered for that day have been signed off as being completed, and if not, to investigate the reasoning. The Director of Nursing will monitor the log books on a weekly basis	02/18/2011

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	emboli, constipation, hypercholesterolemia, gastroesophageal reflux disorder, and history of chronic obstructive pulmonary disease. Resident #C's care plans indicated a care plan dated 01/06/11 for the Resident at risk for ecchymosis secondary to anticoagulant therapy and had a goal of "Resident will not have ecchymosis larger than 12.5 centimeters TNR [till next review]." Interventions included, but were not limited to, "Medications and labs as MD ordered." The Physician's Orders dated January 2011 indicated Resident #C had an order for Aspirin [anti-coagulant] 81 mg every a.m., Lovenox [anti-coagulant] 1 mg sq [subcutaneous] every 12 hours, and Coumadin [an anti-coagulant] 5 mg daily, among other medications. The Physician Telephone Orders dated 01/10/11 indicated orders for the following: "... (1) PT/INR on Wednesday 1/12 & call to [name of physician's healthcare facility] ... (2) fasting lipid panel with 1/12 PT/INR draw ...." Review of the January 2011 Medication		as a second check to ensure the charge nurses are getting the lab log book completed accurately. Monitoring will be ongoing.	

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	Administration Record [MAR] indicated the physician's order for the PT/INR had been transcribed onto the MAR, and a date for the lab work to be completed was indicated on 01/12/11. No nurse's initials on the date marked for the lab work indicated blood for the lab work had been obtained. Daily Skilled Nurses Notes dated 01/15/11 at 6 a.m. indicated the resident complained of abdominal pain and nausea. Tylenol was given for abdominal pain and an assessment of the abdomen was made. Bruising was noted on the right side which measured 13 cm x 31 cm dark purple/blue in color with a 3.5 cm x 4.5 cm dark red area that was hard/knot in the center. The left side measured a 5 cm x 13 cm purple/blue/yellow/green bruise. The note also noted an late entry for 3:20 a.m. for a call placed to laboratory due to labs of a PT/INR and lipid panel not drawn which were due on 01/12/11. The notes indicated the medical doctor was notified the the issues via phone at 7:45 a.m. on 01/15/11 and a stat [immediate] PT/INR was ordered and the lab was notified and the lab was drawn. The nurse's notes at 9:30 a.m. on 01/15/11 indicated the resident complained of pain			

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	of a score of 9 on a scale of 1 to 10 with 10 being the highest pain level and 1 very light pain. The knot measured 3.5 cm x 5.5 cm and the medical doctor was paged. Lab results were not back yet. At 9:45 a.m., the medical doctor gave new orders to send Resident #C to the emergency room for evaluation and treatment of abdominal pain and bruising. The resident was sent out and the family was notified. The lab results for 01/15/11 indicated a Prothrombin Time of 17.7 which was high [as reference range was 9.1-11.1] and an INR of 1.8 which was high [as reference range was 0.9 - 1.1]. Notes at 11:55 a.m. indicated the resident returned from the emergency room with new orders to discontinue the Lovenox and to use a heating pad to abdomen as needed. The family was notified. Interview with the Director of Nursing [DoN] on 02/10/11 at 1:15 p.m. indicated when labs are ordered, a lab sheet is filled out and put in a box, then the lab person gets the lab sheets out of the box when they come in to draw the labs. The DoN indicated the order for the 01/12/11 lab draw was put on the MAR.			

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	Interview with the DoN on 02/10/11 at 2:00 p.m. indicated she had called the lab facility and the lab did not have a copy of the lab requisition sheet. Interview with the ADoN on 02/10/11 at 2:40 p.m. when she investigated the missed lab draw, LPN #1 told her [ADoN] that the lab person could not find the resident at the [name of another facility] as the lab person had her listed as a resident at the [name of other facility] instead of Asbury Towers. The ADoN's notes indicated the lab supervisor stated the lab had documented on 01/12/11 that Resident #C was unavailable for the lab draw and they had her down as being at another facility instead of at the resident's current location. The notes indicated the facility had fax confirmation that laboratory received the facility's fax which had Asbury Towers name and address. Review of a written statement by the DoN dated 02/10/11 indicated the following: "I was told by [name of ADoN] that she called lab to find out why [name of Resident #C] was not drawn on 1/11/11. She stated that lab drawer said resident was unavailable for draw that morning. She was not listed on the printed "draw			

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ASBURY TOWERS RETIREMENT COMMUNITY	102 W POPLAR STREET GREENCASTLE, IN46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	sheet" that we receive from the lab listing who is due for what test for the day. The nurse in the health center told me that the lab girl takes the requisitions out of the lab box at the beginning of the month and takes them. I looked through our shred box and found a few from Dec 10 [December 2010] and Jan.11 [January 2011] but not one for [name of Resident #C]. I called lab and spoke to a representative who reported they "never rec'd [received] the order or at least it is not found in their computer system" only the PT/INR for 01/15/2011 was in the system." On 02/10/11 at 4:15 p.m., the day nurse, RN#1, for health care unit indicated the lab sheet which is faxed to the lab has the facility's name and address on it and is filled out by the nurse with the resident's name, room number, date, date of birth, sex, social security number, and the physician's name. This sheet if faxed to the lab, then in return the lab faxes the facility back a sheet with the resident's name and information which are to be drawn on a certain date. After the lab person draws the labs, that sheet is signed by the nurse and the lab person and the sheet goes into a notebook. RN #1 could not find Resident #C's name on the sheets for 01/12/11.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	This federal tag is related to Complaint IN00085414. 3.1-49(a)			